LEGAL DUTIES INVOLVING PHYSICIANS, PATIENTS AND THIRD PARTIES: PART TWO

by DAVID T. ARMITAGE, M.D., J.D. , COL, MC, USA

TARASOFF

In 1973, a malpractice case that had been initially dismissed by a California trial court eventually triggered a medicolegal earthquake. Prior to that time, physicians were occasionally sued when their patients injured third parties through contagious disease or reckless driving.[1] *Tarasoff* has become generic, like Xerox™ to photocopy, for a malpractice case that arises after injury to a third party by a different category of dangerous patient.[2,3,4] It has added a completely novel dimension to physicians' duty to non-patients.

Tatiana Tarasoff was stabbed and shot to death on the porch of her Berkeley, California, home on October 27, 1969. Her killer, Prosenjit Poddar, a University of California student from India, had become romantically obsessed with Tarasoff. He was also pathologically jealous. Having kissed Tatiana once, considered the equivalent of betrothal in his native culture, he became extremely upset when he witnessed her kiss others. Poddar taped his telephone conversations with Tatiana and replayed them continuously, searching for clues of her affection.

At the urging of a friend, Poddar was evaluated by a Student Health Service psychiatrist who determined that hospitalization was not indicated, prescribed a neuroleptic, and referred him for outpatient psychotherapy with a psychologist. During psychotherapy, Poddar acknowledged violent fantasies about Tarasoff, who was temporarily out of the country. He related that he might kill her when she returned. Poddar's friend informed the psychologist that his patient had purchased a gun.

The psychiatrist and psychologist conferred and agreed that Poddar should be hospitalized for further evaluation, against his will, if necessary. They concluded that he was suffering a severe, acute schizophrenic reaction. Unaware that the state law regarding involuntary hospitalization had recently been changed and convinced that he was following proper procedure, the psychologist asked the campus police to apprehend the patient and escort him to the hospital for involuntary evaluation. On August 20, 1969, the campus police interviewed the patient and determined that he was behaving normally and rationally. They exacted a promise that he would not harm Tarasoff.

Poddar never returned to the Student Health Service. He killed Tarasoff shortly after she returned to the United States. Arrested and tried for homicide in the first degree, he was convicted of second degree homicide. That conviction was ultimately overturned on a technicality, and Poddar returned to India.

Tarasoff's parents sued the University of California, the professionals involved, and the campus police. They alleged a negligent failure to hospitalize their daughter's killer. Almost as an afterthought, they also claimed a "failure to notify" them that their daughter was in grave danger.

The parents' suit was initially dismissed. On appeal, an intermediate court affirmed the dismissal after concluding that there was no statutory duty requiring any of the defendants to hospitalize Tarasoff's killer; that the length of time between the attempted hospitalization and the murder was too long to support proximate cause; that the defendants held statutory immunity for discretionary acts; and that, most important for this discussion, the defendants owed no legal duty to the Tarasoffs or their daughter because there was no special relationship between them. One judge strongly dissented, however, and argued that a legal duty to warn existed and provided support for a cause of action.

Echoing that dissent, the California Supreme Court, after hearing the case on appeal in 1974, overturned the dismissal. Noting that the defendants could not escape liability merely because the Tarasoffs were not their patients, the court held that "[w]hen a doctor or psychotherapist, in the exercise of his professional skill and knowledge, determines, or should determine, that a warning is essential to avert danger rising from the medical or psychological condition of his patient, he incurs a legal obligation to give that warning." Quoting from another case, the court stated: "The assertion [of the defendants] that liability must be. . . denied because defendant bears no 'duty' to plaintiff begs the essential question whether the plaintiff's interests are entitled to legal protection against the defendant's conduct . . . ." The court dealt further blows to the defense by emphasizing that their special relationship with a dangerous patient was reason enough to impose that duty.

> [A] patient with severe mental illness and dangerous proclivities may, in a given case, present a danger as serious and as foreseeable as does the carrier of a contagious disease or the driver whose condition or medication affects his ability to drive safely. We conclude that a doctor or a psychotherapist treating a mentally ill patient, just as a doctor treating physical illness, bears a duty to use reasonable care to give threatened persons such warnings as are essential to avert foreseeable danger arising from his patient's condition or treatment.

The court followed a common law principle that an obligation of due care attaches when one voluntarily undertakes to help another. In the opinion of the court, the defendants' efforts to have the killer committed amounted to helping Tatiana Tarasoff. The court also referred to another common law principle that a person whose action causes another to be in danger must give warning to the other. The acts of the psychologist and campus police led Poddar to abruptly discontinue therapy, increasing the danger to Tarasoff. The court dismissed the defendants' argument regarding difficulties with and inaccuracies in predicting patients' future dangerousness. The opinion emphasized that, minimally, the defendants had expressed grave concern about the potential for harm to Tarasoff, the very reason they attempted the involuntary hospitalization of Poddar.

In 1976, the California Supreme Court uncharacteristically agreed to rehear arguments regarding the duty to warn issue.[4] The rehearing followed persistently expressed concerns by the American Psychiatric Association that requiring such a warning could severely compromise doctor-patient confidentiality, a crucial basis and an ongoing support for effective psychotherapy.

The court modified its 1974 duty to warn, subsuming it under a broader duty to protect. In the 1976 opinion, *Tarasoff II,* the court stated:

> [O]nce a therapist does, in fact, determine or under the applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger. While the discharge of that duty . . . will necessarily vary with the facts of each case, in each instance, the adequacy of the therapist's conduct must be measured against the traditional negligent standard of the rendition of reasonable care under the circumstances.

The court noted that the duty to protect might be discharged in various ways, such as issuing a warning to the intended victim "or others likely to apprise the victim of the danger," notifying police, or initiating "steps reasonably necessary under the circumstances."

The defense had reiterated an argument that a lack of warning was justified because of the legal obligation to respect doctor-patient confidentiality. The court replied "that the public policy favoring protection of the

confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins." Furthermore, the court noted that the California Evidence Code specifically waived the statutory psychotherapist-patient communication privilege when disclosure was required "to prevent threatened danger."

Addressing psychiatry's concern about the poor predictive value of clinical determinations regarding potential for violent behavior, the court declared that any unreliability in prediction does not negate a duty to protect. It considered the risk of unnecessary warnings a reasonable cost for saving potential victims. At the same time, the court discouraged rote disclosures of all threatening comments, apparently unaware of the serious problems that would arise clinically when practitioners tried to walk the tightrope of this newly minted legal standard.

So powerful was the response to *Tarasoff* by psychiatrists across the country that many believed the California case applied nationally. As late as 1984, Givelber and his coauthors reported that approximately 90 percent of psychiatrists they surveyed were aware of *Tarasoff*.[5] Most, however, incorrectly believed their legal duty to potential victims was specifically to warn them, rather than to act reasonably to protect them. Clinicians, focusing on the particular facts of *Tarasoff*, where a warning was at issue, apparently failed to appreciate the broader legal standard enunciated.

Tarasoff left a number of issues unclear, one of which concerned the breadth of the duty to protect. In *Thompson v. County of Alameda*, the California Supreme Court subsequently limited the duty to protect to those third parties who were reasonably foreseeable and ***identifiable*** as potential victims at the time of the patient's threat.[6] The case involved a violent, institutionalized juvenile offender who was known to harbor dangerous impulses to harm young children. He had threatened, once discharged from the institution, to murder some unidentified child in his neighborhood. Neither the mother of the juvenile offender, nor anyone else, was warned of this threat when he was released to her custody. Shortly thereafter, he murdered a five-year-old child who lived nearby. The parents of the victim sued the county for having failed to warn them. The court held that a victim, if not named, must be identifiable and that a generalized threat to the public-at-large or a segment thereof would not support an affirmative duty to warn.

Despite the limit imposed by *Thompson*, *Tarasoff* left the medical community, especially psychiatry, in an uproar. Worrisome issues remained: what is adequate to insure protection; what effect will a breach of confidentiality have on a patient's willingness to continue psychotherapy; what is "reasonable" when determining who might be a foreseeable victim; how does one meet illusory professional standards of danger assessment; how much control can be exerted over a patient; does informed consent require a patient to be advised of the psychiatrist's duty to protect others; and how would other states react to *Tarasoff*? Some of these have been addressed in subsequent cases and with legislation.

POST-*TARASOFF* TRENDS

Early Cases

New Jersey seized the baton in 1979 and agreed with *Tarasoff* that there is a legal duty to protect third parties and that confidentiality is not absolute.[7] Referring to earlier cases that involved the duty of a physician to warn or protect third parties from patients' contagious diseases and also relying heavily on *Tarasoff*, the court held:

> . . . that a psychiatrist or therapist may have a duty to take whatever steps are reasonably necessary to protect an intended or potential victim of his patient when he determines, or should determine, in the appropriate factual setting and in accordance with the standards of his profession established

> at trial, that the patient is or may present a probability of danger to that person. The relationship giving rise to that duty may be found either in that existing between the therapist and the patient, as was alluded to in *Tarasoff II*, or in the more broadly based obligation a practitioner may have to protect the welfare of the community, which is analogous to the obligation a physician has to warn third parties of infectious disease. . . . To an admittedly uncertain but nevertheless sufficient extent, 'dangerousness' must be considered identifiable . . . and although not a 'disease' as that term is commonly used, may affect third persons in much the same sense as a disease may be communicable.

The court noted that terms such as duty, dangerous, dangerousness, reasonableness, and beauty all have abstract qualities and "may be difficult or impossible to define in absolute and precise terms, even when applied to specific facts." The court also implied that psychiatrists historically had both assessed and predicted patients' behavioral qualities and, therefore, should not complain they were being unfairly burdened. The specific facts in the New Jersey case were elaborate, tortured, and highly controversial. Nevertheless, an expert witness had testified convincingly that the defendant physician was grossly deviant in failing to warn an identifiable victim of a clearly dangerous patient.

In another case, a federal district court held that Nebraska law required a psychotherapist to "initiate whatever precautions are reasonably necessary to protect potential victims of his patient . . . when, in accordance with the standards of his profession, the therapist knows or should know that his patient's dangerous propensities present an unreasonable risk of harm to others."[8] The case created a stir because the opinion articulated a duty to protect when, under the factual circumstances, no victim could have been identified.

A patient had undergone inpatient psychiatric treatment followed by day-hospital care at a Veterans Administration medical center. After purchasing a shotgun, a fact unknown to the hospital staff, the patient withdrew from the day-hospital program against medical advice. A month later, he fired the shotgun into a crowded nightclub, wounding the plaintiff and killing her husband. No threats toward nightclub patrons had been voiced, although the patient, when disgruntled, had uttered generalized threats that were not considered serious by the medical staff.

The plaintiff alleged that the VA knew or should have known of the patient's dangerousness and that he should have been involuntarily hospitalized. Because the case was settled out of court, it is impossible to analyze how the district court judge would have dealt with the specific facts of the case, in light of the expanded duty referenced. The court did state that no liability would be imposed upon a physician who, using due care and proper professional techniques, allows his patient the freedom of a less restrictive environment and injury to a third party results. The court also noted that, because psychiatric assessment necessarily involves some degree of uncertainty, negligence "may not ordinarily be found short of serious error or mistake . . . ."

Reviewing post-*Tarasoff* decisions, one legal commentator argued that foreseeability had become the pivotal issue.[9] Courts held physicians liable only when the injured party was known to the physician or known to be close to the object of violence. Further, threats were specific, and the patient's history was replete with dangerous behavior that had been overlooked or improperly discounted. Courts had not held physicians liable when, at the time of assessment, a patient posed no realistic threat to any identifiable individual. In 1982, a federal court in *Hasenei v. U.S.* found VA physicians not liable for failing to protect motorists who suffered injuries when one of their patients, acutely alcohol intoxicated, crashed head-on into another car in an apparent homicide/suicide attempt.[10]

The patient, while on active duty, had been treated at an Army medical center for severe alcoholism and paranoid schizophrenia. At that time, he acknowledged both suicidal and homicidal thoughts. Having im-

proved significantly, he was transferred to a Veterans Administration hospital near his home in Pennsylvania for transitional care prior to a medical separation from the military.

Following a brief but unremarkable hospitalization, the patient was discharged to outpatient care. For unknown reasons, he did not attend the outpatient clinic for four months, three months later than planned. He then reported that his son had been killed in the interim. Having blamed himself, the patient further reported that he had begun drinking intermittently but not heavily. This history was supported by the patient's wife in conversations with the hospital's social services personnel. The patient subsequently described, however, a number of concurrent successes in his life, and he expressed hope for an improved future. No suicidal or homicidal ideation was evident. The psychiatrist changed the patient's neuroleptic medication and scheduled a follow-up appointment in one month. Days later, the man committed suicide in a vehicular crash that injured others. The injured victims sued the federal government.

The plaintiffs alleged foremost that VA physicians had negligently failed to hospitalize or, in some other manner, control the patient. Applying Pennsylvania law, the federal district court concluded that the VA physicians owed no legal duty to the motorists, because they had no legal right or ability to control the patient. The court stated that control was simply a special form of protection and that common law principles still applied: there is no duty, in the absence of a special relationship, to control another.

The district court noted, somewhat critically, that no court recognizing a *Tarasoff* duty had ever indicated what was intrinsic to the doctor-patient relationship that made it "special" and thereby legally granted the doctor either the right or the ability to control a patient. The usual doctor-patient relationship, especially one involving an outpatient, does not involve control. Relationships that involved control were exemplified by parents and children, masters and servants, land owners and licensees, and persons officially responsible for those with dangerous propensities, such as prison authorities with regard to convicts. The court found no similar relationship in the case under consideration. Moreover, the patient in question never met Pennsylvania standards for involuntary commitment, from which a duty for the psychiatrist to take control of the patient might have been derived.

The plaintiffs also argued that the VA physicians should have prevented the patient from driving, because he was a known alcoholic who had expressed suicidal thoughts in the past. The court dismissed this argument, given the facts proven in the case and the judge's conclusion that there was nothing that the physicians could have done to prevent the patient from driving.

This federal court was unwilling to accept *Tarasoff*. The court appears to have been more receptive to arguments regarding limitations on the ability of psychiatrists to predict future rather than imminent dangerousness. In that context, a lack of foreseeability can eliminate the element of proximate cause necessary to prove negligence. Courts in Maryland and Florida have also affirmatively rejected *Tarasoff*.

Other Jurisdictions

In a federal case from Kansas, later affirmed by the United States Court of Appeals for the Tenth Circuit, a jury held hospital physicians liable for the death of a patient's parents.[11] The patient had been hospitalized after threatening his grandparents, with whom he lived. After three months, he was discharged with a diagnosis of passive-aggressive personality and sociopathic tendencies. He was sent to another state to live with his parents. One week later, he murdered them.

The estate of the parents sued for negligent release of the patient from the hospital. Addressing questions certified by the federal appellate court, the Kansas Supreme Court declared negligent release of a patient with violent propensities a valid cause of action for malpractice. In so doing, the court sidestepped whether

a duty to warn or protect third parties existed in Kansas under circumstances involving a potentially dangerous patient. The court indicated that third parties have a right to be free of injury that arises from a physician's malpractice, a clear departure from the generally accepted limitation of such a right to those, as patients, who are under the doctor's direct care. Earlier cases allowed for liability to third parties premised upon either a duty of ordinary care or a duty arising out of a special relationship, but not one emanating from simple negligence on the part of a doctor.

The Kansas opinion leaves unclear how a duty to avoid injuring patients by substandard medical care evolves into a duty to non-patients. The duty to a patient is distinguishable, however, from the duty to non-patients, because the duty to third parties requires a physician to take affirmative action outside the usual course of medical care to protect them. The closest the court came to justifying this opinion was to quote at great length prior cases involving infectious diseases that recognized a physician's legal obligation to the public at large.

In summary, Kansas has acknowledged a cause of action, sounding in professional negligence, for the wrongful release of a dangerous patient, already under a physician's control, who subsequently injures a third party. The third party need not be identifiable, and the patient need not have made threats specific to the person injured. In this context, foreseeability appears to mean that, when a patient makes a general threat to harm someone, anyone in the world who is later injured can file suit.

The Supreme Court of Vermont faced the *Tarasoff* challenge in 1985.[12] A 29-year-old mental health clinic patient expressed a desire to seek revenge for a past rejection by his father. When asked about a plan, he mused that he could always burn down his parents barn, a structure located approximately 130 feet from his parents' house. After discussing the consequences of such an act with his counselor and promising not to burn the barn, the patient left the clinic. His counselor did not discuss this interview with her supervisors. The next night, the patient burned the barn. The parents sued the clinic for their property loss and alleged malpractice by the counselor in failing to take reasonable steps to protect them from their son.

The case was eventually dismissed by a trial court on the basis that there was no such duty to protect in Vermont. On appeal, the Vermont Supreme Court reversed, holding that such a duty did not differ substantially from legal obligations to warn in order to protect the public health. The defendants had cited *Hasenei v. U.S.* to support their argument that a counselor lacks sufficient control over an outpatient to support a duty to third parties.[10] The court rejected this, echoing *Tarasoff* that the relationship between therapist and patient is enough to create a duty to protect. The defendants argued further that the counselor had made a good faith assessment of her patient's intent and that she should not be held liable for a simple error in judgement.

The Supreme Court agreed, however, with the trial court's conclusion that the counselor had not acted as a reasonably prudent counselor, because she not only acted on inadequate information but also failed to seek consultation. The court concluded "that a mental health professional [defined by Vermont as a physician, psychologist, social worker, nurse, or other qualified person designated by the commissioner] who knows or, based upon the standards of the mental health profession should know that his . . . patient poses a serious risk of danger to an identifiable victim has a duty to exercise reasonable care to protect him . . . from that danger."

Historically, arson has been treated as a very serious crime, because it poses great risk of bodily harm. In this case, however, and unlike all other reported third party cases, no person was injured. Therefore, in Vermont, the danger to be warned of, and from which plaintiffs are to be protected, is not a

danger to the victim's person, as *Tarasoff* implied, but to the victim's property interest! No other jurisdiction has followed Vermont's example.

In a Wisconsin case, a husband and daughter sued the psychiatrist of their bipolar wife and mother for medical negligence that they alleged had substantially contributed to an auto accident that caused the death of the patient, as the driver, and paralyzed the daughter.[13] They claimed that the psychiatrist had failed to timely diagnose, commit, or properly medicate the patient and that there was a failure to warn the family about both her dangerous psychotic condition and the adverse effects of her medication.

On appeal from a dismissal of the case, the Wisconsin Supreme Court granted the plaintiffs a cause of action, because: (1) a psychiatrist could be held liable for failing to warn about the side effects of medication adversely affecting driving ability, given the foreseeability of injury to both the patient and third parties; and (2) a physician has an affirmative duty to warn or to institute commitment proceedings to protect nonipatients even if threats are not directed toward an identifiable "target."

Confidentiality must yield to public safety. Warnings can be made to family members or to the police, but commitment of a mentally ill and dangerous patient may be the only effective recourse for the psychiatrist. The court recognized that the relative unlikelihood of an injury resulting from the alleged negligent behavior might, in a particular case, preclude the imposition of liability on a public policy basis (e.g., fairness, limiting litigation). Stated differently, proximate cause might not be demonstrable and, therefore, negligence would not be proven. This opinion is noteworthy, because the affirmative duties to warn and to protect by involuntary hospitalization are recognized for the sake of third parties.

North Carolina, on the other hand, has decided not to impose an affirmative duty on physicians to seek involuntary commitment of dangerous patients for the protection of third parties.[14] Providers cannot be held accountable for third party injuries inflicted by a patient who is voluntarily committed because they are not granted legally sufficient control over such a patient to support the imposition of liability. Once a patient is hospitalized involuntarily, however, and the staff has the legal power to restrain, negligent failure to do so can result in liability for third party injuries.

In the cited case, the court noted that, even if North Carolina subscribed to a duty to warn, that duty would not extend to a third party already aware of the patient's violent tendencies or to an individual unidentified by the patient as a potential victim.

Florida: Anticipating the Future

Recently, an appellate court in Florida determined that the state's confidentiality statute, in force when the case under consideration arose, barred the imposition of *Tarasoff*.[15] One judge on the appellate panel warned, however, that it would be "premature for us to express any view on the existence and scope of any duty", in light of amendments to the state's law that had been enacted in the interim.

A young man had been killed by a psychiatric outpatient. The victim's father sued the psychiatrist and alleged negligent failure to hospitalize or to prescribe proper medications for the patient. He also alleged that the defendant had failed to warn the deceased, his parents or the police that the patient was prone to violence and had threatened the victim with serious harm. The complaint listed no specific threats because the psychiatrist, referring to Florida law that prohibited disclosure of confidential psychotherapist-patient communications, had refused to release the patient's records. Nevertheless, the plaintiff alleged, in accordance with *Tarasoff*, that the psychiatrist knew or should have known that the patient had threatened to harm the victim and that the psychiatrist's negligence had proximately caused the victim's death.

The court rejected the "enlightened" [sic] *Tarasoff* approach and the cases from other jurisdictions that had followed California. The court stated that: 1) Florida law, in the absence of a special relationship, imposes no duty to control another's behavior or to warn endangered third parties; 2) a special relationship must include the ability or the right to control; 3) the relationship of a psychiatrist and a voluntary outpatient lacks the necessary elements of control; 4) a duty to control cannot be transformed into a duty to warn or protect; 5) such a transformation would impose an unreasonable duty on psychiatrists, psychologists, psychotherapists, and "other mental health practitioners"; 6) it is unfair to impose such a duty because psychiatry is an inexact science characterized by wide disagreement among practitioners regarding diagnosis, treatment and the likelihood of future dangerousness; 7) it is virtually impossible to reliably or accurately predict dangerousness; 8) "to impose a duty to warn or protect third parties would require the psychiatrist to foresee a harm which may or may not be foreseeable, depending on the clarity of his crystal ball . . . . [I]t would be fundamentally unfair to charge a psychiatrist with a duty to warn"; 9) imposing a duty to warn would "wreak havoc with the psychiatrist-patient relationship", the corner-stone of which is confidentiality; and 10) Florida law prohibits the disclosure of confidential psychiatrist-patient communications to third parties.

A critical dissenting opinion, similar to that in the initial appeal of *Tarasoff*, includes the following:

> The court says that, no matter what the underlying circumstances, no matter how great the danger, no matter how trivial the effort required to prevent the harm, no matter what the proof concerning the likelihood that even a phone call might have saved the human life, no jury could properly hold Dr. Burglass civilly responsible. I cannot agree with a conclusion which seems to me to be so contrary to the requirements of a civilized society and therefore to what should be the standards of our law.

After the case commenced, but prior to its resolution, the Florida legislature enacted a statute that, when a patient being treated by a psychiatrist made an actual threat to physically harm an identifiable victim, and a threat which, in the clinical judgement of the psychiatrist, the patient is capable of and will more likely than not carry out in the near future, "the psychiatrist ***may*** disclose patient communications ***to the extent necessary to warn*** any potential victim or . . . law enforcement agency." [emphasis supplied.] The dissenting justice in *Boynton* argued that the newly enacted statute merely reflected Florida's preexisting public policy supporting the imposition of a legal duty to warn. The majority dismissed his argument and emphasized that the permissive "may" in the statute was aimed at immunizing psychiatrists from liability for a breach of confidentiality in circumstances where the psychiatrist's best judgement raised a moral duty to warn. Recall that other courts have concluded that once a psychiatrist makes such a clinical judgement, a legal duty arises to warn or protect.

In a law review article highly critical of the Florida decision, the author concluded that "the court improperly reached its results by taking improper judicial notice of marginally relevant, outdated, and controversial research regarding the state of modern psychiatry."[16] He referenced alternate research supporting "a substantially more optimistic view of psychiatry's prediction of dangerousness." Therefore, foreseeability of injury is indeed reasonable. Furthermore, preexisting Florida legislation authorized psychiatrists to involuntarily hospitalize patients based on a finding of mental illness with dangerousness.

This commentator noted that the state relies upon psychiatric evaluations for granting bail bonds, authorizing purchase of firearms, and sentencing criminals. The courts have regularly held members who practice "inexact science" liable for malpractice, indicating that standards do exist and that sufficient "exactness" can be determined to allow liability to be imposed on the basis of public policy and fairness. Moreover, medical practice involving infectious diseases, such as tuberculosis, is not as exact as the Florida court postulated, and "certainty" has never been a required legal basis for imposing liability.

Lastly, the author criticized the opinion's analysis of control and confidentiality. Most physicians who diagnose and treat contagious diseases have little control over their patients. Florida case law arguably allowed a broader definition of control than did the court. The Florida court neglected studies demonstrating that laws requiring physicians to breach confidentiality to meet a duty to warn had little effect on the access to or provision of psychiatric treatment. In addition, Florida law need not and should not be read as demanding an unyielding right of confidentiality.

Considering the conflicting opinions in *Boynton,* as well as the scholarly criticisms generated in its wake, one would be pressed to accurately predict the future reception of *Tarasoff* in Florida.

LEGISLATION

Currently, at least ten states have enacted specific statutes that address the duty to warn third parties about, or protect them from, a behaviorally dangerous patient.[17] Generally, these laws require that a patient must communicate a threat to a mental health care provider, and they immunize the provider from liability for a breach of confidentiality. The laws differ with regard to who owes the duty to protect, the type of threats that give rise to the duty, the identifiability of the victim, and the manner or criteria by which the duty is discharged.

All these statutes impose a duty on psychologists, but, interestingly, the Minnesota law does not specify psychiatrists. The duties of nurses, social workers and "professional counselors" are delineated in some statutes. Indiana and Colorado impose the obligation to protect upon certain legal entities, such as college counselling centers and community mental health centers.

Uniformly, the laws require that there be an utterance or some behavior on the part of a patient that constitutes a threat of physical violence to another individual. Some require that the threat be "serious", the violence "imminent, or "specific means" for bringing about the injury be communicated. The standard for victim identification ranges from "reasonably identifiable" (most states) to "clearly identified." Each of these laws also mandates the actions required to discharge the duty, including the means by which potential victims and law enforcement officials are to be notified.

FINAL THOUGHTS

By court decision and legislation, the law, following the lead of medicine, seems to view the psychiatric patient as special. This viewpoint undoubtedly reflects a number of social, cultural and historical beliefs, even biases. Judicial opinions analogize and distinguish between patients made dangerous by their mental illness and those who are dangerous by virtue of other medical conditions. The law, in certain circumstances, has expanded the duty of health care providers to protect third parties while narrowing it in others.

One medicolegal expert has stated that, although both law and medicine "agree that society deserves protection from violence and that breaching psychotherapist-patient confidentiality is sometimes necessary, there is little consensus about the most effective manner in which to protect third parties."[9] As a result, mental health providers find themselves afloat in a sea of legal chaos, potentially held liable by a system that can be both arbitrary and unfair.

References on next page.

REFERENCES

1. Armitage DA. Legal duies involving physicians, patients, and third parties: Part one. Legal Medicine Open File. 1994; 94-2: 7-12.

2. *Tarasoff v. the Regents of the University of California, et al.,* 108 Cal. Rptr. 878 (1973).

3. *Tarasoff v. the Regents of the University of California, et al.,* 529 P.2d 553, 118 Cal. Rptr. 129 (1974). [*Tarasoff I.*]

4. *Tarasoff v. the Regents of the University of California, et al.,* 551 P.2d 334, 131 Cal. Rptr. 14 (1976). [*Tarasoff II.*]

5. Givelber D, *et al. Tarasoff,* myth and reliability: An empirical study of law in action. Wisconsin Law Review. 1984; 2: 443-497.

6. *Thompson v. County of Alameda,* 614 P. 2d 728, 167 Cal. Rptr. 70 (1980).

7. *McIntosh v. Milano,* 168 N.J. Super. 466, 403 A. 2d 500 (1979).

8. *Lipari v. Sears, Roebuck & Co.,* 497 F. Supp. 1985 (1980).

9. Mills MJ. The so-called duty to warn: The psychotherapeutic duty to protect third parties from patients' violent acts. Behavioral Sciences and the Law. 1984; 2: 237-257.

10. *Hasenei v. U.S.,* 541 F. Supp. 999 (1982).

11. *Durflinger v. Artiles,* 727 F.2d 888 (1984).

12. *Peck v. the Counseling Service of Addison Count, Inc.,* 146 Vt. 61, 499 A.2d 422 (1985).

13. *Schuster v. Altenburg,* 424 N.W.2d 159 (Wis. 1988).

14. *Cantrell v. U.S.,* 735 F.Supp. 670 (1988).

15. *Boynton, Sr. v. Burglass,* 590 So.2d 446 (Fla. 3rd Dist. Ct. App. 1991).

16. Greenberg AC. Florida rejects a *Tarasoff* duty to protect. Stetson Law Review. 1992; 22: 239.

17. Geske MR. Statutes limiting mental health professionals' liability for the violent acts of their patients. Indiana Law Journal. 1989; 64: 391.